

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

01-01

2. STATE:

Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

March 16, 2001

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 430.12 (b)

7. FEDERAL BUDGET IMPACT:

a. FFY 2001 \$ 0

b. FFY 2002 \$ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Page 89

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Page 89

10. SUBJECT OF AMENDMENT:

State Governor's Review

GOVERNOR'S REVIEW (Check One):

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☒ OTHER, AS SPECIFIED:Review delegated to Interim Committed
Commissioner
Dept for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Ellen Hesen

14. TITLE:

Interim Commissioner, Dept for Medicaid SWS

15. DATE SUBMITTED:

16. RETURN TO:

Sharon Rodriguez, Manager
Policy Coordination Branch
Dept for Medicaid Services
275 East Main Street 6EA
Frankfort, KY 50621**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

March 16, 2001

18. DATE APPROVED:

March 20, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

March 16, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

Eugene A. Grasser

22. TITLE:

Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

Revision: HCFA-PM-91-4 (BPD)
August 1991
State/Territory: Kentucky

OMB No. 0938-

Citation 7.4 State Governor's Review

42 CFR 430.12(b)

The Medicaid Agency will provide opportunity for the Office of Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Health Care Financing Administration with such documents.

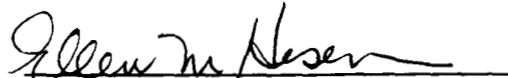
- ☒ Not Applicable. The Governor-
☒ Does not wish to review any plan material.
☐ Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

Department for Medicaid Services

(Designated Single State Agency)

Date: March 16, 2001


(Signature)

Ellen Hesen, Interim Commissioner
Department for Medicaid Services
(Title)

TN# 01-01
Supersedes
TN# 98-07

Approval Date MAR 20 2001

Effective Date 3/16/01